or three squeezes, spontaneous respiration did not return for an hour. The patient suffered anoxia, and although partially recovered, she is unable to walk without assistance, unable to dress, undress, bathe, wash herself or comb her hair. She can feed herself partially but has to be prodded to continue eating. She is incontinent of bowel and bladder unless these needs are attended to every three hours, day and night. She speaks slowly, haltingly, unresponsively and without intelligence or intellectual content. She has no memory, no human motivation, is emotionally insulated and unresponsive, and is without spirit or compassion. These conditions are irreversible.

Notes on Medical Liability

Medical Staff Rule Requiring Adequate Professional Liability Insurance

THE Joint Medicolegal Education Committee of the California Medical Association and the California Hospital Association has learned of many instances in which some members of a hospital medical staff carried inadequate professional liability insurance or none at all.

Medical staff organization was developed in the public interest in order for physicians to further their professional training, to assure each other of highly competent colleagues for consultation, and to better administer and discipline the medical care being rendered in a hospital, for which they are responsible.

Many medical and surgical procedures performed in a hospital call for the combined professional skills of several physicians. Each physician should be assured not only of the training and competence of all others, but also that his colleagues have in force adequate professional liability insurance. The welfare of your patients in the event of injury caused by another physician, is thus better protected, as is your own estate. The point should be emphasized that the uninsured or underinsured physician is a hazard to the other physicians on the staff due to the fact that in the event a suit joins a number of physicians, an increased burden may be placed on those who are adequately insured.

Recently, a questionnaire was sent to the 789 medical staff members of two large hospitals in a metropolitan area to ascertain whether they carried malpractice insurance and what the amount of their coverage was. Replies were received from 620 members or 78 per cent. No malpractice insurance was carried by three physicians. Nineteen carried coverage up to $5,000 and 27 had $15,000 limits. Approximately 15 per cent of those responding carried $50,000 limits or less.

The C.M.A.-C.H.A. Joint Medicolegal Education Committee recommended that hospital medical staffs require that every member of the staff shall annually file an informal statement with the secretary of the staff, telling the amount of professional liability insurance he is carrying and the name of the underwriting company. This information will be reviewed by the executive committee of the staff in order that all staff members may be assured that each member has reasonably adequate professional liability insurance in force. No permanent record need be kept of this information. The executive committee shall develop, from time to time, criteria (informal), by which to measure what shall be considered reasonable, adequate limits of coverage and shall advise the members of the medical staff of their recommendations.

These proposals are made in the interest of the profession and the public. They have been approved by the C.M.A. Council.

Joint Liability of Physician Cooperating With Another Discipline

A RECENT DECISION by a California court provides a timely reason to review the matter of the joint and several legal liability of physicians when they assist other disciplines.

Before an oral surgeon who is not a physician may admit a patient to a hospital for a procedure he is qualified to perform, a physician must give the patient a physical examination. An anesthesiologist ordinarily must administer the anesthesia. In some circumstances, the negligence of one may be shared by the other. For example: Who must recognize and treat pneumonia or drug reactions?

Dental work may be required because of infection, or an infection may result from it. The treating physician, in his effort to locate the cause of an illness that may be connected with the dental work, may be required to make careful x-ray examination of the area in which the dental work was done. The dentist may also be required to take x-ray films.

The District Court of Appeals, First District, Division 2, California, in December, 1959, handed down an opinion in the case entitled "William

George v. J. E. Matthews and W. C. Nixon, 346 Pac. 2d 863," in the course of which some interesting observations were made. The plaintiff, one William George, consulted Doctor Nixon, a physician, in December, 1952, and complained of a low backache which had persisted for several years. After examination, Doctor Nixon recommended that the plaintiff see a dentist. The plaintiff saw Doctor Matthews who found him suffering from pyorrhea and recommended extraction of all his teeth. On January 16, 21 and 28, and February 6, 1953, George's teeth were extracted by Doctor Matthews. On January 29, George had a low-grade fever, rash and rapid pulse. Doctor Nixon was called and administered an injection of penicillin. On February 6 and 16, another such injection was given. On February 20, George was suffering chills, consulted Doctor Nixon and was placed in the hospital. A diagnosis of septicemia was made. X-ray films were taken of George's jaw but the films did not show the portion of the jaw where, subsequently, some broken teeth roots were observed. On March 5, George was discharged from the hospital and he also relieved Doctor Nixon of any further responsibility for his care. George consulted another doctor. On March 11, he was again placed in the hospital. A diagnosis was made of septicemia with rheumatic arthritis and staphylococcal lobar pneumonia empyema. X-ray studies disclosed broken teeth roots in the upper jaw. Following removal of the broken roots, George's temperature became normal and his chest cleared.

An action was filed by George against both Doctor Nixon, his physician, and Doctor Matthews, his dentist, for alleged incompetent treatment in the extraction of his teeth. A judgment was rendered against both defendants in the trial of the case. Doctor Nixon appealed the decision. Upon review of the testimony, the court held that there was evidence produced that by reason of the prolonged infection and fever, the plaintiff's health was permanently impaired. There was evidence that the pockets of pus in the sockets of the broken teeth roots were the chief cause of the plaintiff's trouble. There was testimony that the standard of practice in San Francisco, the locality where this took place, required that:

1. With infection in the plaintiff's mouth, his physician should have given him an antibiotic injection on the day of or day before any teeth were extracted, and

2. The physician should have had adequate x-ray films of the patient's jaw taken when he was put in the hospital to determine whether broken roots remained.

There was evidence produced that it was the duty of the physician rather than the dentist to determine whether or not an antibiotic should be employed. Based on this evidence, the court submitted this matter to the jury under proper instructions. The Court of Appeals held that the jury's verdict holding, in effect, that both the dentist and the physician had not applied the proper standard of care in this case, was supported by the evidence. Incidentally, the jury awarded damages in the amount of $55,000.

This case would seem to impose upon a physician, a joint duty to almost supervise the completeness or adequacy of another professional man's work which may be the cause of or contribute to an illness which is being treated by the physician. A physician, therefore, who would undertake to do the necessary workup for a dentist, upon which that patient could be admitted to a hospital, may be required to continue an interest in that case to insure that side effects do not occur which are outside the professional competence of the dentist.

Physician Assisting Chiropodist

The Business and Professions Code of California, Section 2139, defines chiropody as follows:

"Chiropody means the diagnosis, medical, surgical, mechanical, manipulative and electrical treatment of the human foot including the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. No chiropodist shall do any amputation or use an anesthetic other than local."

The State Board of Medical Examiners asked the attorney general two questions concerning this section:

"1. Can Chiropodists perform any surgery on the muscles of the leg or foot?

"2. Does the portion of Section 2139 beginning 'Chiropody means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot' mean that a Chiropodist can do any surgery on the human foot, not requiring a general anesthesia?"

The opinion of the attorney general is dated December 20, 1944, and is reported in 4 Opinions Attorney General 386. The attorney general, in the course of the opinion, ruled it to be his opinion that this legislation indicated that as to "the foot itself, surgical treatment was contemplated or permitted and that when the Legislature permitted treatment of the muscles and tendons of the leg governing the functions of the foot, it believed that it was necessary to limit the treatment of such enlarged area to nonsurgical treatment." The attorney general stated that "Chiropodists may perform

surgery on the foot, not involving amputation." He may not perform surgery on the muscles of the leg which govern the functions of the foot. The attorney general further stated: "We do not consider that the type of anesthetic has any relation to the extent or type of surgery that may be performed. . . . What surgery would amount to amputation, or what amount or type of anesthetic would be local, is a technical question of fact which must be determined by a person skilled in the art."

Should an anesthesiologist be called to assist a chiropodist who surgically treats a patient's foot, the anesthesiologist, since he is a physician, might well be held responsible to treat the side effects resulting from the surgical treatment or the use of drugs which are beyond the competence of the chiropodist.

Chiropodists Not Eligible for District Hospital Staff Membership

California Attorney General's Opinion No. 59-318, dated May 6, 1960, ruled:

"Chiropodists may not be admitted to membership on the medical staff of a local hospital district under the present legislation."

The attorney general's opinion was sought by an assemblyman.

After carefully reviewing the various statutes, the attorney general concluded that:

"Membership in the medical staff of a local hospital district is limited to physicians and surgeons and dentists."

It would appear that for a chiropodist to surgically treat a foot in a district hospital, the patient would need to be admitted by a staff physician. That physician would probably be held responsible for the medical needs of the patient arising outside the competence of the chiropodist.

Fortunately, problems of the nature discussed here do not arise with great frequency. But the inter-relationship between physicians and other disciplines is most necessary, important and frequent. An understanding of potential problems tends to decrease them.